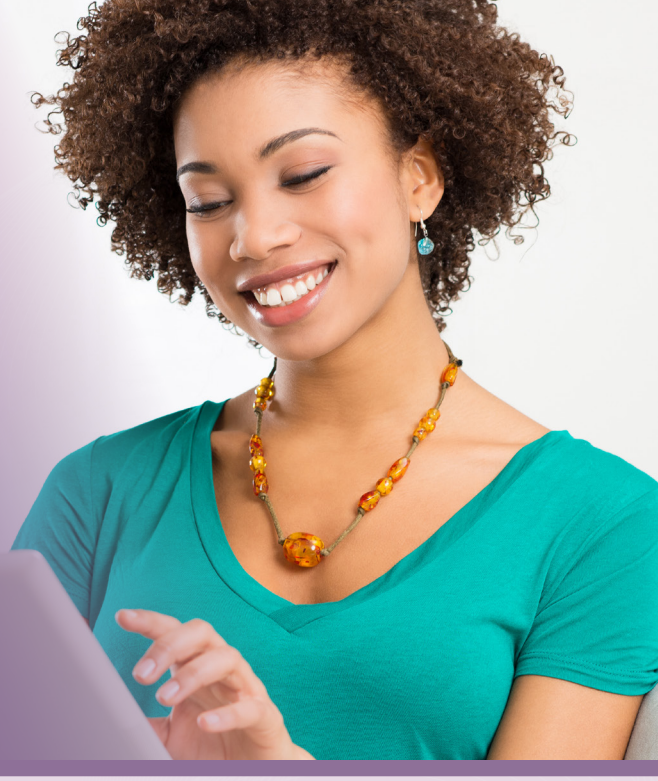
Women Heart®
The National Coalition for Women with Heart Disease

Know Your Rights:
Breaking Through Barriers to Care



Even women with health insurance encounter barriers to treatment. Here's how that happens—and what to do about it.

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Most challenges in getting the treatment your doctor ordered happen in one of two ways:

1. Nonmedical switching. This means that you must change medications, though it's not because your doctor ordered a switch. Instead, the insurance company has made a change to your plan, usually to cut costs. This change makes continuing your medications more expensive for you—in some cases too expensive for you to afford. (Note: Nonmedical switching generally does not refer to substituting a generic medication for a brand name.)

What does nonmedical switching look like?

- Eliminating the drug from the list of medications that are covered.
- Increasing the out-of-pocket costs for the drug.
- Moving the drug to a more expensive cost tier.
- Reducing the maximum plan coverage for the drug.
- Adding restrictions like requiring prior authorization.

Often taking place during the plan year, after you are already locked in, these changes can cause new symptoms or side effects that may actually increase the overall cost of your medical care.

2. Denial of care. This means that your doctor's recommended treatment isn't covered by insurance or that coverage is limited. If you haven't received the care yet, you've encountered a **preauthorization denial**. If you have already received the care, that's called a **claims denial**.

What should I do?

The path for challenging nonmedical switching and denial of care is similar.

> ***The key is staying organized and understanding the process. When you call your insurance provider, be polite but firm. Take notes, get names, and record dates of your calls.***

Step 1: Investigate the reasons.

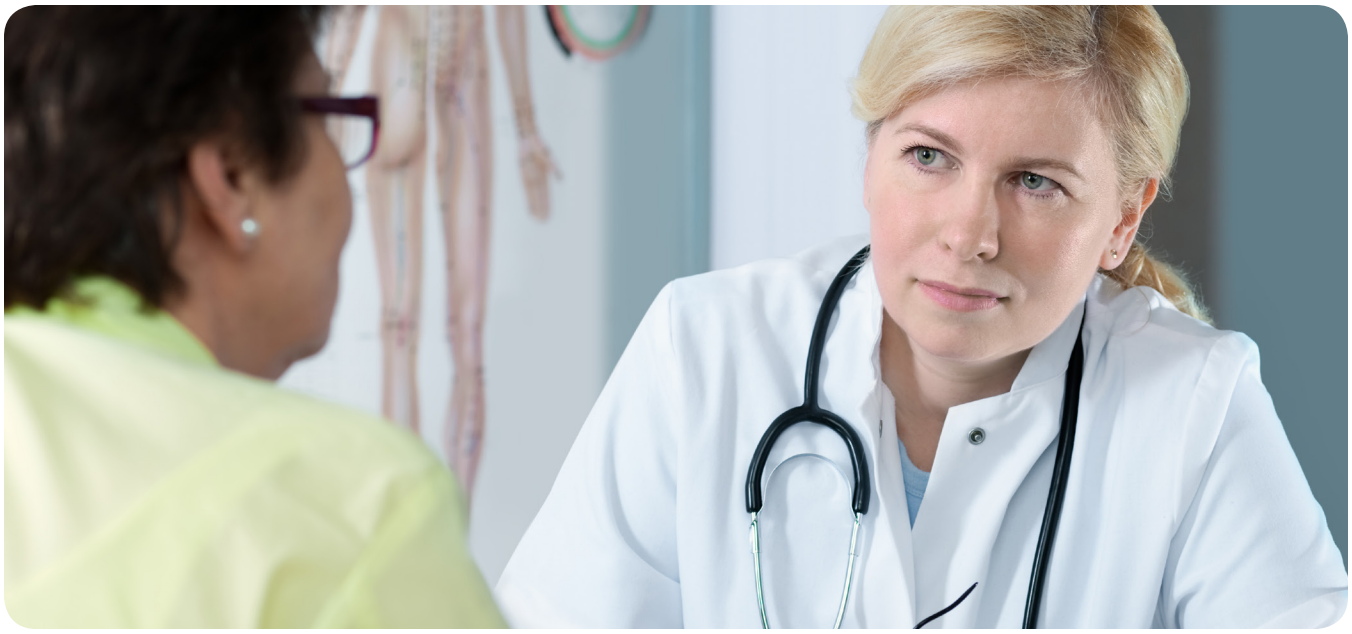
- Call your insurance provider.
- Examine your Explanation of Benefits (EOB) or Denial Letter, which must explain the reason for the denial and how to appeal the decision. Read carefully; sometimes what appears to be a denial actually shows costs that you are responsible for based on your plan's coverage.
- Go to your health plan's website to confirm what is covered.

Sometimes there's a simple reason for the denial, or the decision was made in error. For example:

- You didn't follow basic procedures, like getting preauthorization or going to an in-network provider.
- The bill went to the wrong insurance company (common if you have more than one insurance plan).
- You have not yet met your deductible for the year.
- You've reached your maximum annual plan payment.
- The claim has a data entry mistake, like a misspelled name or wrong ID number or date of service.
- The claim is missing information or documentation.
- The claim was filed too late (if this is your doctor's fault, you may not be responsible).
- The pharmacy has outdated insurance information.

Other, more complicated, reasons for a denial include:

- The insurance company doesn't consider the treatment to be medically necessary.
- The service is not a covered benefit under the plan.
- The service must be performed in a specific hospital or other specific health care setting.
- The service is considered experimental or investigational for your condition.
- You are not eligible for the service requested.



For medications, denials that are not nonmedical switching may be based on factors like these:

- The drug was not in the plan's formulary when you signed up for the plan.
- You are required to use another medication first.
- You've reached the medication limit, either in terms of dosage or quantity.
- You must use a different pharmacy or use mail order.
- The health plan will only cover the generic version of the drug.

Step 2: Take action, correct errors, and ask for help.

Once you've figured out the reason that care was denied, you'll be ready for your next steps:

- Ask your medical provider to correct and resubmit the claim.
- Find out if your doctor can request a retroactive prior authorization.
- Purchase the medication without your insurance and/or determine if financial assistance is available.
- Identify state resources or an advocate or ombudsman who can intervene.

Step 3: File an appeal.

In most cases you have the right to appeal. **Your health plan can't drop your coverage or raise your rates if you do.**

The purpose of the **first appeal** is to prove that your claim meets the insurance guidelines and that it was rejected incorrectly. Carefully review your plan and determine how the care fits into a category that the insurer covers in the plan. You'll need to explain that in an **appeal letter**, which can be written by you, your medical provider or an advocate on your behalf. Your appeal letter should include the following:

> ***"Your health plan can't drop your coverage or raise your rates if you file an appeal.***

- A **summary** of your health problems and the treatments you have tried.
- A **statement of medical necessity** from your doctor that explains your condition and the reason the treatment is being ordered. You may be successful if you can show that your treatment is already the **standard of care**, which refers to a general treatment process a doctor follows for a specific illness or set of symptoms. It is also known as a **best practice** and follows treatment plans that are agreed upon by experts in the field.
- Documentation that **Medicare** or other insurance companies already cover this treatment.
- A request by your physician to speak with the medical reviewer of the insurance plan as part of a **peer-to-peer review**.
- Supporting evidence such as **medical journal articles** or **treatment guidelines** from recognized organizations like the American Heart Association.
- Evidence or **cost comparisons** that the prescribed medical service will save the insurance company on future expenses, such as readmissions to the hospital.

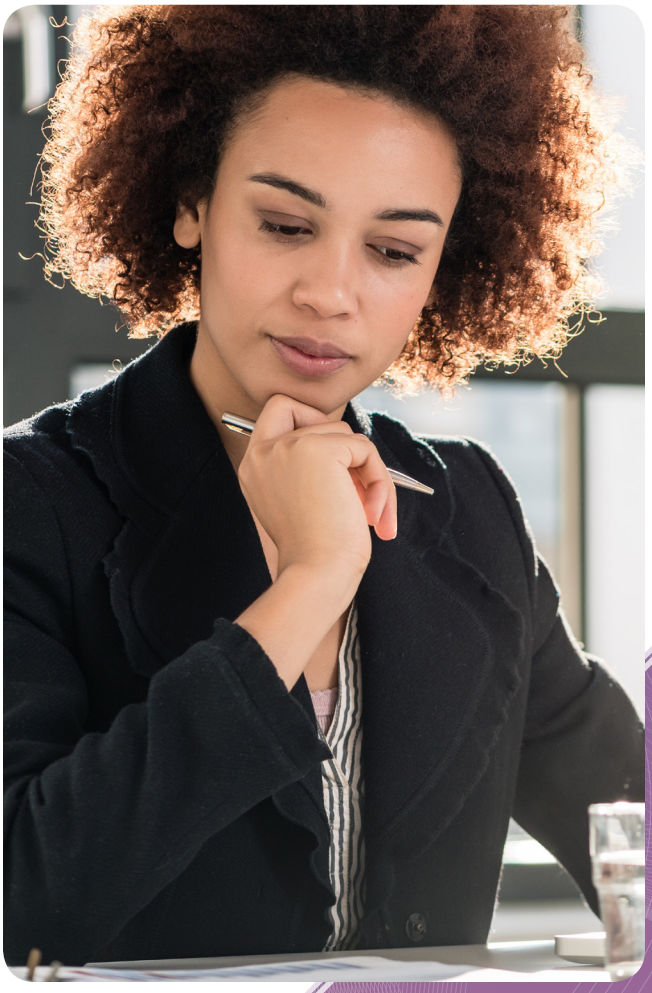
Keep a copy of all correspondence and be sure to send it before the deadline for appeals. Each level of appeal has different deadlines; these are listed on your denial letter or explanation of benefits. Send your letter via certified mail or with a tracking receipt. Insurance companies are required to respond within 7 to 10 days.

Second Level Appeals are typically reviewed by a medical director of your insurance plan who was not involved in the claim decision. There also may be an additional level of appeals to determine if the care is experimental or investigational. (If that's the case, you may want to investigate if the treatment is offered through a free clinical research trial.)

Note: You can file an urgent appeal if your physician believes a delay could seriously jeopardize your life or overall health. Your insurer must respond to an expedited request within 24 to 72 hours.

Step 4: Pursue an external review.

If you aren't satisfied with the insurance plan's final response, you may have the option for an **external review by an independent third party** who usually collaborates with a physician who is board-certified in the same specialty as



your physician. These can only be requested for denials related to covered services and not those that are identified under your plan as exclusions or treatments that are not covered. An external review/appeal will either uphold the insurance company's decision or decide in your favor by overturning all or part of the health plan's decision.

Step 5: Seek legal advice.

If the above steps don't help, you may wish to seek legal advice and settle the matter in court.

Step 6: Notify your elected officials.

New consumer-protection laws are enacted all the time. Notifying your local legislators may help to put important issues on their radar.

Who Can Help?

Here are some of the resources ready to assist you:

- your physician
- your human resources dept. (if your plan was purchased through your employer)
- state agencies and elected officials
- patient advocacy organizations

KeepMyRx
www.keepmyrx.org

Alliance for Patient Access
www.allianceforpatientaccess.org

Patient Advocate Foundation
www.patientadvocate.org

National Association of Insurance Commissioners
www.naic.org

U.S. Department of Health and Human Services
https://www.hhs.gov/regulations/complaints-and-appeals/index.html

Center for Consumer Information and Insurance Oversight
www.cms.gov/CCIIO

Employee Benefits Security Administration, U.S. Department of Labor
(for participants or beneficiaries in employer-sponsored health plans)
www.askebsa.dol.gov or (866) 444-3272

Glossary of Terms

Nonmedical switching: Health insurance plans or drug benefit managers make changes to their drug coverage benefits. These are not for medical reasons; the purpose is reducing business costs. These changes often make it too expensive for patients to continue taking the drugs that their physicians have recommended and that have stabilized their symptoms.

Denial of care: You learn through your Explanation of Benefits or in a Denial Letter that your physician's recommended treatment plan is either not covered by your insurance or the coverage is very limited.

Preauthorization denial: Notification before you receive treatment that your insurance plan will not cover the treatment.

Explanation of benefits: A statement sent by a health insurance company to those covered by their plan explaining what medical treatments and/or services are being paid to the provider on their behalf.

Claims denial: Notification that the specific treatment you have already received will not be paid for by your insurance plan.

Statement of medical necessity: A statement by your health care provider that explains why a treatment is necessary based on your medical condition.

Standard of care: A general treatment process a doctor follows for a specific illness or set of symptoms. It is also known as a *best practice* and follows protocols that are agreed upon by experts in the field.

About WomenHeart

Our mission is to improve the health and quality of life of women living with or at risk of heart disease, and to advocate for their benefit.